# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07974

Reg. Dist. No. 100

**1. PLACE OF DEATH:**
County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County St Mary's
City or town Mechanicsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war none

**3.(a) FULL NAME** William Buckler

**3.(b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | widowed |

B.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 4 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 8 | 2 | hrs. ..... min. |

9. Birthplace St Mary's Co - Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Thomas Jefferson Buckler
13. Birthplace St Marys Co Md

MOTHER
14. Maiden name Elizabeth Taylor
15. Birthplace St marys Co Md

16. Informant Carrie Buckler
Address Mechanicsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/45 (month) (day) (year)
Cemetery or crematory St Joseph
Location Maryland Md
18. Funeral director Edwin McDonald
Address Hughesville Md
19. 8/8 1945 (Date rec'd by registrar) Julia Posey Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945, at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-45 19.., to 8-7-45
and that I last saw h... alive on 8-6-45 19..
Immediate cause of death 7-45 am

| | DURATION |
|---|---|
| Acute Myocardial Hypertension | 7 days |
| Cerebral accident | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions | |
| | |

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold A D'Arcy M.D. or other
Address Hughesville Md Date signed 8/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07963

## CERTIFICATE OF DEATH

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Charles
City or town: Pomonkey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Pomonkey
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Josephine Hoody Carroll

**3.(b) Social Security Number:**

4. Sex: Female
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of husband or wife: William F. Carroll.
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): April 18, 1886
8. AGE: Years: 59. Months: 4 Days: 12 If less than one day: ____ hrs. ____ min.
9. Birthplace: Norfolk Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own Home.
12. FATHER — Name: Not known
13. FATHER — Birthplace
14. MOTHER — Maiden name: Not known.
15. MOTHER — Birthplace
16. Informant: Taylor Daniel Carroll
Address: Bryans Road. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 3 1945 (month) (day) (year)
Cemetery or crematory: Metropolitan M.E. Church
Location: Pomonkey, Md.
18. Funeral director: Pomonkey & Cofer
Address: Mason Springs, Md.
19. 9-2-1945 (Date rec'd by registrar) M. E. Ransome P.L. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1945 at 8 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 21 1945 to Aug 30 1945 and that I last saw h...er alive on Aug 30 1945

| | DURATION |
|---|---|
| Immediate cause of death: Acute myocarditis | 3 months |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lucille Susan L.S. M. D. or other
Address: Indian Head, Md. Date signed 8/31/45

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27-a)

## CERTIFICATE OF DEATH

07968

Reg. Dist. No. 100

**1. PLACE OF DEATH:**

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [redacted] 27 hrs.

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? [redacted] 27 hrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: [redacted] Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Charles Edward [redacted] Colbert

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Single |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June —, 1945

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | ? | ...hrs. ...min. |

9. Birthplace: Waldorf, Charles, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER — 12. Name: Osborne Colbert

13. Birthplace: Chas. Co, Md

MOTHER — 14. Maiden name: Frances McKee

15. Birthplace: Chas. Co, Md

16. Informant: Frances Colbert

Address: Waldorf, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-45 (mouth) (day) (year)

Cemetery or crematory: St. Peters

Location: Waldorf, Md

18. Funeral director: Hewitt & Byron

Address: Waldorf, Md

19. 8-20 19 45 (Date rec'd by registrar) Julia H Penny Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1945, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 18 1945, to Aug. 19 1945

and that I last saw h[redacted] alive on Aug. 18 1945

| Immediate cause of death | DURATION |
|---|---|
| Bacillary dysentery | 8 days |
| Due to: | |
| Due to: | |
| Other conditions: Malnutrition, ? marasmus | ? |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John I. MacKenzie, M.D. M. D. or other

Address: La Plata, Md [redacted] Date signed 8-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07972

Reg. Dist. No. 1-20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Charles

City or town: Newburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En Route

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Port Tobacco (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

**3.(a) FULL NAME:** Harvey Ernest Everetts

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Nellie Everetts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 190

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation: Laborer Saw mill

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: Unknown

15. Birthplace

16. Informant: V. L. Hills (Employer)

Address: La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-45 (month) (day) (year)

Cemetery or crematory: Mt Rest

Location: La Plata md

18. Funeral director: Hewett & Ryan

Address: Waldorf Md

19. 8-20 19 45 Julia H. Posey Registrar (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17, 1945 at about 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17, 1945, to ..... 19..... and that I last saw him alive on Aug. 17, 1945

| Immediate cause of death | DURATION |
|---|---|
| Fractured cervical spine | Minutes |
| Due to: Automobile accident | |
| Due to: | |
| Other conditions: Multiple fractures of all long bones | |

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8-17-45

Where did injury occur? Newburg (City or town) Charles (County) Md (State)

Injured at home, farm, industry, public place (where?) State highway 301

Means of injury: Wagon hit by auto Injured at work? No

23. SIGNATURE: James L. MacKenzie, M.D. Deputy Medical Examiner M. D. or other

Address: La Plata Md Date signed 8-18-45

07975

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Charles
City or town: La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Mary E Johnson

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | B | Wid |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 8 - 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 3 | 9 | ..... hrs. ..... min. |

8. Birthplace Chas Co Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Rachael A. Darsey
15. Birthplace Chas Co Md

16. Informant Joseph P. Johnson Jr
Address La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-45 (month) (day) (year)
Cemetery or crematory St Marys
Location Bryantown Md

18. Funeral director Hutchins & Ryon
Address Waldorf Md

19. 8-20 19 45 - Julia H. Posey (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/45 19..... at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/12-45 19..... to 8-17-45 19.....
and that I last saw h... alive on 8-16/45 19.....

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 5 yrs |
| Due to Cardiac Decompensation | 6 wks |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Data of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lewis A Tucker M. D. or other
Address Dentsville Date signed 8/19/45

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 100 07971

1. PLACE OF DEATH:
County Charles
City or town Bialton md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or strset address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Md County Charles
City or town Bialton md
(If outside city or town limits, write RURAL and give nearest town)
Strsst No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie L. Mudd

3.(b) Social Security Number

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | N | Wid |

6.(b) Name of husband or wife Harter
6.(c) If alive, give age ysars

7. Birth date of deceased (mo., day, yr.) Nov 6 1880

| 8. AGE: Ysars | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 9 | 9 | hrs. min. |

8. Birthplace Chas Co md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Robert L. Cook
13. Birthplace Chas Co md
MOTHER 14. Maidsn name Alice L. Dutton
15. Birthplace Chas Co md
16. Informant Madeline Mattingley
Address Indian Head md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-16-45 (month) (day) (year)
Cemetery or crsmatory St Ignatius
Location Bel Alton md
18. Funsral dirsctor Hewitt & Payne
Address Waldorf md
19. 8/16 (Date rec'd by registrar) 19 45 Julia H. Pacey Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 45 at 4 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 19 42 to Aug 15 19 45 and that I last saw h.r alive on August 15 19 45

| | DURATIDN |
|---|---|
| Immediate cause of death | |
| Chronic Myocarditis | 5 yrs |
| Due to | |
| Due to | |
| Dthsr conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death shonld be charged statistically.

22. VIOLENCE: If dsath was due to external causes, fill in the following:
Accidsnt, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public piece (whsre?)
Means of injury Injured at work?

23. SIGNATURE Emmit Spencer Jr M.D.
M. D. or other
Address Bel Alton md Date signed 8-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119a

## CERTIFICATE OF DEATH

07976

Reg. Dist. No. 104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Charles
City or town: Pope Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Limestonehill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Mary M. Proctor

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | NB | Single |

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1-5-43 6.(c) If alive, give age years

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| | 7 | 22 | hrs. min. |

9. Birthplace Pope Creek (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Benjamin Newman

13. Birthplace Bel Alton Md

MOTHER 14. Maiden name Mary M. Proctor

15. Birthplace Bel Alton Md

16. Informant Joseph Proctor

Address Pope Creek

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-43 (month) (day) (year)

Cemetery or crematory St Ignatius

Location St Thomas Manor

18. Funeral director James H. Proctor

Address Waldorf Popes Creek Md

19. 8-29-1943 (Date rec'd by registrar) Wm. Proctor Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 8-26-1943 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-26-1943 to 8-27-1943 and that I last saw h alive on 8-27-1943

| | DURATION |
|---|---|
| Immediate cause of death: Cholera Infantum | |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Hayden M. D. or other

Address Waldorf Date signed 8-28-43

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (950)

# CERTIFICATE OF DEATH

07973

Reg. Dist. No. 100

**1. PLACE OF DEATH:**

County Charles

City or town Hughesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Charles

City or town Hughesville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** THOMAS TOLLA.

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | White | married |

6.(b) Name of husband or wife LENA SCABO (TOLLA)

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1867

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 11 | 7 | ...hrs. ...min. |

9. Birthplace APATIN HUNGARY (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER

12. Name PETER TOLLA

13. Birthplace HUNGARY

MOTHER

14. Maiden name ELIZABETH WOELFLING

15. Birthplace HUNGARY

16. Informant NICHOLAS TOLLA

Address Hughesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/45 (month) (day) (year)

Cemetery or crematory St Mary's

Location Brantown

18. Funeral director EMER M QUADE

Address Hughesville Md

19. 8/8/45 (Date rec'd by registrar) Julia H. Posey Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to Aug 7 1945 and that I last saw him alive on Aug 7 1945

| Immediate cause of death | DURATION |
|---|---|
| Acute Cardiac Dilatation | 1 hr |
| Due to | |
| Due to Senile Debility of old age | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE I D Chapman M.D. M. D. or other

Address Hughesville Md Date signed 8/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

## CERTIFICATE OF DEATH

★ 07970 108

Reg. Diat. No. .....

**1. PLACE OF DEATH:**

County ..... Charles

City or town ..... La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 41 hrs.

Hospital, institution, or street address where death occurred:

..... Physicians Memorial Hospital

How long in hospital or institution? ..... 41 hrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State ..... Md. County ..... Charles

City or town ..... Indian Head

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

**3. (a) FULL NAME** James Magruder Vernon, Jr.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 8.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife ..... —

6.(c) If alive, give age ..... — years

7. Birth date of deceased (mo., day, yr.) August 27, 1945

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 1½ | ..... hrs. ..... min. |

9. Birthplace ..... La Plata, Charles Md.

(Town, county, and state)

10. Usual occupation ..... Infant

11. Industry or business

FATHER

12. Name ..... James Magruder Vernon

13. Birthplace ..... Waldorf Md.

MOTHER

14. Maiden name ..... Mary Alice Simms

15. Birthplace ..... Pomfret, Md.

16. Informant ..... Mrs. James M. Vernon,

Address ..... Indian Head, Md.

17. Burial Date thereof 8-29-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Paul Piney

Location Waldorf Md

18. Funeral director Hiatt & Ryon

Address Waldorf Md

19. Aug 29 19 45 M P Middleton

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... August 28, 1945, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 27, 1945, to Aug. 28 1945

and that I last saw h.. alive on Aug. 28, 1945

| Immediate cause of death | DURATION |
|---|---|
| Massive atelectasis | 41 hrs. |
| Due to Accident during birth (aspiration) | |
| Due to Spontaneous fetal breech delivery — uncomplicated | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... —

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James L. MacNamara M.D.

M. D. or other

Address La Plata, Md. Date signed 8-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15